Continuity of Care Advisory Panel

Social Workgroup Presentation

October 23, 2013

Spring Grove Hospital Center (Dix Building)

(1 pm – 3 pm)

Attendees:

Clarissa Netter

Anita Smith Everette

Laura Cain

Kait Roe

Gayle Jordan-Randolph

Rianna P. Matthews-Brown

John Boronow

Erik Roskes

Erin McMullen

Janet Edelman

Lois Fisher

Herb Cromwell

Sarah Rhine

Crista Taylor

Sarah Rhine

Randy Nero

Eric Wiggins

Brian Hull

Zereana Jess-Huff

Elaine Carroll

Tim Santoni

Susanne Harrison (phone)

Mike Finkle

Lori Doyle

Stephen Goldberg

Sarah R. Eyster (phone)

Darrell Nearon

Stacy Reid Swain

Evelyn Burton

Presenters: The Co-Chairs of the Social Workgroup distributed their power point handout to attendees and callers accessed the presentation via the website link.

Clarissa Netter (Co-Chair) presented on the following Social Barriers to Continuity of Care after discussing the Social Determinants of Health: Urban vs. Rural (Workforce/Transportation)

Dr. Anita Smith-Everett (Co-Chair) presented on the following Social Barriers to Continuity of Care: Housing/Gender/Gender Identity/Sexual Orientation/Language/Race and Ethnicity

Workgroup Participants Comments:

Herb Cromwell: With respect to the recommendation on slide 16 about ***amending RRP-related regulations, I object to this recommendation*** for the same reasons Scott Rose articulated in another workgroup when an RRP discharge hearing process was discussed -- and rejected. RRPs are a community service, not a state hospital. We have worked with MHA for years on steps (see 10.21.21.08 on "managed intervention plans" and 10.21.22.10 related to discharge) to help folks remain in RRP whenever possible including in times of crisis. Providers take seriously that an RRP is someone's home but providers also need to have discretion in light of things like the safety of other residents. As far as we are concerned, no further regulations are needed. It's a matter of systems accountability more so than amending RRP regulations.

Kait Roe: I would encourage DHMH to create a place for LGBT information. is responsible to come to so it can be managed; Governor to have a cabinet position; Secretary of DHMH to have LGBT; outreach to practicing mental health providers who do not take Medicaid or medicare and outreach to LGBT community; getting data that will help decide whether MD is likely to discriminate in the same way NY with involuntary outpatient commitment; what are the demographics in MD with regard to race in civil commitments; how are we treating people in the criminal system; make accountability responsible for DHMH and not the providers (RRP); can't have people discharged to homelessness

Laura Cain: issue aroung RRP program and discharge (calls from family members and consumers) re: rule violation; housing unit at MDLC has intervened and helped people with housing; issue around consistency; how do we make sure that when a person is discharged inappropriately what recourse do we have and is that a robust avenue for them; people who are getting discharged because the provider can't meet their clinical needs? If safety risk….the system needs to take some responsibility for that person….because the person with the most severe needs is now homeless; Racial studies (on involuntary and inpatient commitment were state hospitals…..AA and other minorities end up in the deepest end of the system)…MD system has changed…have to recognize the different pathways where people end up in the deep ends..we didn't get a chance due to time to discuss other racial minorities (NY evaluation report…statistic on the Latino population 30% of involuntary orders were directed at Latinos….)

Lois Fisher: Disproportionate number of AA in state mental health system (do they have to wait to get arrested to get mental health services); not getting services in the community….mental health services are like a revolving door in certain areas…forensic population

Public Comment:

Evelyn Burton: NY AOT studies….conclusions of the authors based on the data they had compared to the population of the areas they studied…no evidence to conclude that there was evidence of discrimination….what is the racial proportion of people in the mental health system...data is needed…because we don't have AOT for people who don't understand they are ill….they are forced into the mental health system…to get rid of the disparity this would help;

Lois Fisher: if Assisted than it's not forced; Connecticut didn't adopt; 45 states have it but few states use it;

Laura Cain: evaluators claim that it wasn't racial bias that resulted in disproportionate number but that minorities are overrepresented in the group…targeted population….looked at historical perspective…racism exists and racially motivated; studies that AA are more likely to be re-admitted to a hospital after discharge; in NY disproportionate number of orders come out of the city….AA ordered at a rate higher than other groups; look at treatment disparities from the past

to the present at Crownsville; notice about a Bill first read passed city council that would increase penalties for pan-handling and loitering…movement to arrest poor homeless people

Janet Edelman: in response to Lois Fisher

-CT is an outliner in terms of implementing since they have had two major incidents and chose to walk away

-racially motivated/disparities (people who are in minorities are disproportionately represented either out/inpatient

-outpatient much less restrictive than hospital/jail/prison so people don't have to spend their time confined

-taking care of small number of people who need treatment…take care of everyone

-there are sick people who cannot get the services they need in the state

-if you give treatment early on to people who need/want it you don't spend as much money (less homeless services, prisons, jails etc.)

-hoped to have a lot of people testify today with their personal experiences…written testimony will be submitted; each one of the stories is a horror and is happening in our state

Erik Roskes: Patuxent (70% AA prisoners and caseload similar); language (one language difference ASL that is a disability)

John Boronow: support remarks made by Janet Edelman and disagree with misstatements made by Lois Fisher

-sheer speculation of why folks don't get treatment

-exaggeration that "it's a handful of patients"; specific disability with sever psychotic illness that don't know they are sick; profound problem that was not recognized because folks were in hospital where they got care; training from area of institutionalization to de-institutionalization

-folks are eating up the services now

-there is a certain amount of prejudice against my patients; brain disease; real stigma and prejudice

-criminalization of the mentally ill is not a solution

Data Group: November 1st data will be released in grid format (public mental health data and somatic side) will be sent to Stacy Reid Swain and DHMH staff;

Dr. Goldberg: shortages (MD plan that was for psychiatrist to go into state hospitals…); get all mental health professionals out into the rural areas; exposed to the state hospital system in your training; expand the concept to schools of social work, medical etc.; flexible hours for providers (anybody that works it's difficult to make appointments; limiting the system); hold the money back (if you are getting state dollars than require flexible hours); access to dollars you have to some flexibility with office hours; Outpatient Commitment (suggest that the bulk of clinicians that would be involved has a negative intention or undertrained or disproportionately use towards AA….really does not pay attention to what we do everyday on front lines; social stigma; underestimate the value of addressing it publicly; any outpatient commitment/taking away ability for others to access services; not taking money from the general public mental health system and applying it to AOT…we are adding access to a smaller group of people; adding resources; creation of illnesses or anectdotal evidence that's not worthy of our consideration; diagnosis from one field does not apply to another/can't separate diagnosis…implies negative intention…

Linda Raines -people should have the choice of whether or not they want treatment; chairs the coaltion; instead of looking at aggregate data…have real life cases and work it through to determine the solution; what are the cases that we have at our disposal; case by case basis/real people

Zereana Jess-Huff: what are the major barriers for continuity of care (specific cases; challenges vary based on the location of where you are)

*The intended purpose of these meetings is not to propose legislation regarding Outpatient Civil Commitment but to identify barriers to continuity of care and come up with Practical recommendations; we cannot limit mental health services just to the specialty mentally health populations; an opportunity for this workgroup to identify obvious barriers

Carolyn Knight (MOCO member of NAMI): nurse…perspective on how psychiatry has been set off to the side; many people with different kinds of brain disorders/they get treated when they don't understand what's wrong with them; psychiatric practice brought more in line with the rest of the practice disciplines; treat illness that has symptoms of mental disorder; people with good social support systems do better;

Prepared by Stacy Reid Swain